

Notice of Independent Review Decision

**REVIEWER'S REPORT**

**DATE OF REVIEW:** 04/17/10

**IRO CASE #:**

**DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:**

Insurance carrier's denial of physical therapy three times a week for three weeks to the cervical spine and three times a week for three weeks to the left shoulder

**DESCRIPTION OF QUALIFICATIONS OF REVIEWER:**

M.D., licensed in the State of Texas, board certified in AMBS Specialty of Physical Medicine and Rehabilitation for greater than 30 years

**REVIEW OUTCOME:**

Upon independent review, I find that the previous adverse determination or determinations should be:

- Upheld (Agree)  
 Overturned (Disagree)  
 Partially Overturned (Agree in part/Disagree in part)

<i>Primary Diagnosis Code</i>	<i>Service Being Denied</i>	<i>Billing Modifier</i>	<i>Type of Review</i>	<i>Units</i>	<i>Date(s) of Service</i>	<i>Amount Billed</i>	<i>Date of Injury</i>	<i>DWC Claim #</i>	<i>Upheld Overturn</i>
			<i>Prosp.</i>						<i>Upheld</i>

**INFORMATION PROVIDED FOR REVIEW:**

1. Certification of independence of the reviewer and TDI case assignment
2. TDI case assignment
3. Letters of denial, 02/16/10 and 03/11/10 including criteria in the denial
4. Evaluations and followup, 11/25/09 through 03/30/10
5. MRI reports, 01/22/10
6. Work status reports, 11/25/09 through 03/30/10
7. PTE, 01/20/10
8. Preauthorization request, 02/05/10, and appeal, 02/26/10
9. Appeal, 11/30/09
10. Cervical spine and shoulder evaluation, 11/25/09

**INJURED EMPLOYEE CLINICAL HISTORY (Summary):**

The medical records indicate that this individual sustained a slip-and-fall injury on xx/xx/xx, resulting in principle pain report at the base of the neck and upper thoracic area, extending out over the trapezius area to the left shoulder. The patient was evaluated as sustaining sprain/strain type injuries and was placed on physical therapy at approximately a once-a-week basis for a total of twelve therapy sessions. The latest therapy note of 03/30/10 indicated that the patient was no longer having much pain in the neck area. The patient appears to have been working with some restricted duty during the period of time since her injury. There is no indication within the medical records of any invasive pain management treatment. There is evidence of having undergone a left shoulder MRI scan on 01/22/10 and a cervical MRI scan on 01/22/10. There is no report of any orthopedic referral nor any recommendation for any surgery within the

documentation reviewed. Following completion of the approximate twelve sessions of physical therapy, there was the additional request for further supervised therapy.

**ANALYSIS AND EXPLANATION OF THE DECISION, INCLUDING CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT DECISION:**

Review of the very limited medical documentation of the patient's therapy indicates no evidence of a documented physical therapy evaluation by a licensed physical therapist, no documentation of each individual therapy treatment session noting quantitatively amounts of exercise or weights involved, and no identification of who the treating individual was and what their qualification level was to provide such therapy. Based on the ODG Treatment Guidelines, there is failure to adequately document in a written objective fashion each individual treatment session received. There is an overall apparent direction even within the very limited records including both amount of documentation and legibility of such records that the patient has been able to continue work, does have evidence of improvement in symptoms, and no documentation as to why the patient is not able to continue on a self-directed home exercise program as recommended by the ODG.

**DESCRIPTION AND SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE YOUR DECISION:**

- \_\_\_\_\_ ACOEM-American College of Occupational & Environmental Medicine UM Knowledgebase.
  - \_\_\_\_\_ AHCPR-Agency for Healthcare Research & Quality Guidelines.
  - \_\_\_\_\_ DWC-Division of Workers' Compensation Policies or Guidelines.
  - \_\_\_\_\_ European Guidelines for Management of Chronic Low Back Pain.
  - \_\_\_\_\_ Interqual Criteria.
  - \_\_\_\_\_ Medical judgment, clinical experience and expertise in accordance with accepted medical standards.
  - \_\_\_\_\_ Mercy Center Consensus Conference Guidelines.
  - \_\_\_\_\_ Milliman Care Guidelines.
  - \_\_XX\_\_ ODG-Official Disability Guidelines & Treatment Guidelines.
  - \_\_\_\_\_ Pressley Reed, The Medical Disability Advisor.
  - \_\_\_\_\_ Texas Guidelines for Chiropractic Quality Assurance & Practice Parameters.
  - \_\_\_\_\_ Texas TACADA Guidelines.
  - \_\_\_\_\_ TMF Screening Criteria Manual.
  - \_\_\_\_\_ Peer reviewed national accepted medical literature (provide a description).
  - \_\_\_\_\_ Other evidence-based, scientifically valid, outcome-focused guidelines (provide a description.)
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